



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

BAYLOR HEALTH CARE SYSTEM  
2001 BRYAN ST SUITE 2600  
DALLAS, TX 75201-3005

#### **DWC Claim #:**

**Injured Employee:**

**Date of Injury:**

**Employer Name:**

**Insurance Carrier #:**

#### **Respondent Name**

TEXAS MUTUAL INSURANCE CO

#### **Carrier's Austin Representative Box**

54

#### **MFDR Tracking Number**

M4-08-3838-01

#### **MFDR Date Received**

FEBRUARY 19, 2008

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary Dated June 11, 2005:** "Per DWC rule 134.401 Subchapter E – Health Facility Fees (6) Stop Loss Method: Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker. This methodology shall be used in place of \_and not in addition to the per Diem based reimbursement system ... Claim should have paid at stop loss threshold. Total bill charges \$92350.44 @ 75% = \$69262.83. Texas Mutual deducted implants from total bill charges and paid claim at the TDI per diem rate + cost + 10% of implants. "

**Amount in Dispute:** \$40,954.42

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary Dated March 7, 2008:** "Texas Mutual reviewed the medical records and other information furnished by the hospital to Texas Mutual with the billings and/or the hospital's request for medical dispute resolution. Those records do not show that the required services rendered during the admission were unusually costly or unusually extensive ... In this dispute, the requestor has not provided any additional information to justify the required services were unusually costly or unusually extensive. "

**Response Submitted by:** Texas Mutual Insurance Company

### **SUMMARY OF FINDINGS**

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
February 23, 2007 through February 27, 2007	Inpatient Hospital Services	\$40,954.42	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

#### **Explanation of Benefits**

- CAC-W1 – Workers compensation state fee schedule adjustment
- CAC-16 – Claim/service lacks information which is needed for adjudication additional information is supplied using remittance advice remarks codes whenever appropriate
- CAC-97 - Payment included in the allowance for another service/procedure
- 225 – The submitted documentation does not support the services being billed we will re-evaluate this upon receipt of clarifying information
- 480 – Reimbursement based on the acute care inpatient hospital fee guidelines
- 730 – Denied as included in per diem rate
- CAC-143 – Portion of payment deferred
- CAC-W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology
- CAC-W4 – No additional reimbursement allowed after review of appeal/reconsideration
- 420 – Supplemental payment
- 426 – Reimbursed to fair and reasonable
- 891 – The insurance company is reducing or denying payment after reconsideration

### **Issues**

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

### **Findings**

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection..." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold."

Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed..." Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$92,350.44. The division concludes that the total audited charges exceed \$40,000.

2. The requestor in its original position statement asserts that "Per DWC rule 134.401 Subchapter E – Health Facility Fees (6) Stop Loss Method: Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker. This methodology shall be used in place of \_and not in addition to the per Diem based reimbursement system ... Claim should have paid at stop loss threshold. Total bill charges \$92350.44 @ 75% = \$69262.83. Texas Mutual deducted implants from total bill charges and paid claim at the TDI per diem rate + cost + 10% of implants." In its position statement, the requestor presupposes that it is entitled to the stop loss method of payment because the audited charges exceed \$40,000. As noted above, the Third Court of Appeals in its November 13, 2008 rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually extensive services." The requestor failed to discuss or demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).
3. In regards to whether the services were unusually costly, the requestor presupposes that because the bill exceeds \$40,000, the stop loss method of payment should apply. The third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must **demonstrate** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to discuss the particulars of the admission in dispute constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).
4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
  - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission..." The length of stay was four days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of four days results in an allowable amount of \$4,472.00.
  - The division notes that 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bills finds that the following items were billed under revenue code 0278 and are therefore eligible for separate payment under §134.401(c)(4)(A) as follows:

Rev Code	Itemized Statement Description	Cost Invoice Description	UNITS / Cost Per Unit	Total Cost	Cost + 10%
278	Implant, Cancellous Crush	Description from cost invoice	6 at \$335.00 ea	\$2,010.00	\$2,211.00
278	Implant, Ortho	No Invoice provided	\$0.00	\$0.00	\$0.00
278	Impalant, Screw	No Invoice provided	\$0.00	\$0.00	\$0.00
TOTAL ALLOWABLE				\$2,211.00	

The division concludes that the total allowable for this admission is \$4,472.00 + 2,211.00. The respondent issued payment in the amount of \$23,826.00. Based upon the documentation submitted, no additional reimbursement

can be recommended.

### **Conclusion**

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to discuss and demonstrate that the disputed inpatient hospital admission involved unusually extensive, and unusually costly services. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

_____	_____	10/19/12
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	10/19/12
Signature	Medical Fee Dispute Resolution	Date

### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****  
**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**